MONTANA
Department of Public Health & Human Services

ANNUAL SURVEY OF HOSPITALS 2006
(With Patient Origin)

PLEASE RETURN THIS SURVEY NO LATER THAN JANUARY 31, 2007.

Mail or fax a typed or clearly printed copy to: Department of Public Health and Human Services, Certificate of Need Program, 2401 Colonial Drive, 2nd Floor, P.O. Box 202953, Helena, Montana 59620-2953.

Name and Address of Facility:

E-Mail Contact:

Important instructions for completing specific parts of the survey begin each section and are marked with the ✖character.

A. REPORTING PERIOD

✖ **The preferred reporting period is January 1, 2006 through December 31, 2006**. It is permissible to use a different 12-month period, but please be consistent from year to year and indicate the time period used. Report data for a full 12-month period (365 days).

1. Indicate reporting period used.
   Beginning __/__/____ and ending __/__/____
2. Was the facility in operation 12 full months at the end of the period? ☐ Yes ☐ No

B. CLASSIFICATION

✖ **Not For Profit** means excess revenue retained by corporation and exempt from federal income taxation.

1. ☐ NOT FOR PROFIT ☐ FOR PROFIT
2. a. Please name owner of facility (county, corporation, etc.)
   b. Please name management firm of facility (N/A if management is not provided through contract)
3. a. Is the facility operated as part of a chain, whether for profit or not?
   ☐ Yes ☐ No
   b. If YES, please give the name and address of the PARENT organization.

C. UTILIZATION OF BEDS AND SERVICES

✖Report utilization for a full 12-month period.

4. **Neonatal.** Please include data for admissions and inpatient days; bassinets are not included in the number of licensed beds, therefore they are not included in this bed utilization data.

9. **Other.** This category should NOT include any long-term care facility (skilled nursing) beds operated as part of a combined facility. The utilization of long-term care beds should be reflected on the facility's Annual Survey of Long-Term Care Facilities.

10. **Total.** The sum of the individual categories of licensed beds MUST equal the total number of hospital beds for which the facility is licensed by the State of Montana.

BED AND SERVICE CATEGORIES	BEDS LICENSED	BEDS STAFFED	ADMISSIONS	INPATIENT DAYS
1. GENERAL MEDICAL/SURGERY (ADULT)				
2. GENERAL MEDICAL/SURGERY (PEDIATRIC)				
3. OBSTETRICS				
4. NEONATAL (ICU and intermediate care)	Bassinets are not included in bed licensure.			
5. ICU/CCU				
6. REHABILITATION				
7. PSYCHIATRIC				
8. CHEMICAL DEPENDENCY				
9. OTHER				
10. **TOTAL**				
Swing beds should include only those beds certified as swing beds; other long-term care facility (skilled nursing) beds should NOT be included in this section. The number of swing beds should reflect the number of swing beds for which the facility is licensed by the State of Montana.				
11. SWING BEDS				

D. OTHER FACILITY INFORMATION

1. SURGERIES	INPATIENT	OUTPATIENT	TOTAL

2. OPEN-HEART SURGERY (NUMBER OF PROCEDURES)	ADULT	PEDIATRIC	TOTAL

3. DEATHS	FETAL	ALL OTHERS	TOTAL

4. NUMBER OF BASSINETS		
5. NUMBER OF BIRTHS		
6. NUMBER OF NEWBORN DAYS		

E. PERSONNEL DATA

✖ Exclude volunteers and all personnel whose salary is financed entirely by outside research grants. For combined facilities, report **ONLY HOSPITAL** personnel.

6. **All other health professional and technical personnel** refer to speech, occupational, physical, respiratory therapists, x-ray and laboratory technicians, etc.
7. **All other personnel** refer to cooks, housekeeping and an estimate of FTEs for shared personnel in combined facilities.

	FULL-TIME (35 HR/WK)	**PART-TIME** (<35 HR/WK)
1. Administration	____	_____
2. Physicians	____	_____
3. Dentists	____	_____
4. Nursing services (RN, LPN, CNA)	____	_____
5. Physician Assistants/Nurse Practitioners	____	_____
6. All other health professional and technical personnel	____	_____
7. All other personnel	____	_____
8. TOTAL (All Categories)	____	_____

F. FINANCIAL DATA

✖ Report expenses for the full 12-month period. If actual figures are not available, please estimate (indicate which figures have been estimated). Round to the nearest dollar. **Do not include financial data from other combined facilities such as clinics, home health agencies, or long-term care.**

1. a. **Gross revenue:** The total billing revenues from inpatient and outpatient care, and all other **HOSPITAL** sources.
   b. **Net revenue:** This is the gross revenue minus the contractual revenue (deductions); the revenue actually received by the **HOSPITAL**.
   c. **Payroll expenses:** Report salaries for full-time and part-time personnel as reported in section E, Personnel Data. **Benefits** should also be included in payroll expenses.
   d. **Non-payroll expenses:** Include all costs for goods and services that have been used or consumed by the **HOSPITAL** during the reporting period.

1. Total annual operating expenses from most recent financial statement:

a. Gross revenue	$_____
b. Net revenue	$_____
c. Payroll expenses (include benefits)	$_____
d. Non-payroll expenses	$_____
e. Total expenses	$_____

2. Closing date of financial statement: __/__/____

Please compare financial data with 2005 Annual Survey financial data and explain any differences exceeding ten percent.

3. Facility's operating revenue by payor source.

			Gross	Net
A. Government	(1) Medicare:		$_____	$_____
	(2) Medicaid:		$_____	$_____
	(3) Other:		$_____	$_____
B. Non-government	(1) Self-pay		$	$_____
	(2) Third-party payors:			
		HMOs	$_____	$_____
		PPO	$_____	$_____
		Other	$_____	$_____
C. Total			$_____	$_____

G. PATIENT ORIGIN DATA

✖ Please complete this information on pages 5 through 9. Report all patients discharged from the facility for the reporting year by zip code and county of origin. Please total discharges from all counties on page 9.

PLEASE RETURN THIS SURVEY NO LATER THAN JANUARY 31, 2007.

DATE SURVEY COMPLETED __/__/____

ADMINISTRATOR'S NAME (type or print)

ADMINISTRATOR'S SIGNATURE

If we have questions about any of the responses on this survey, whom should we contact?

NAME **TELEPHONE**

If you have any questions, please contact the Certificate of Need Program, Department of Public Health and Human Services, 2401 Colonial Drive, 2nd Floor, P.O. Box 202953, Helena, Montana 59620-2953. Telephone (406) 444-9519, Fax (406) 444-1742, or E-mail to psourbeer@mt.gov

Thank you!

G. PATIENT ORIGIN DATA FORM - 2006

County
Number of discharges by zip code for each city/town
Total for county

BEAVERHEAD
59724 DELL
59725 DILLON
59732 GLEN
59736 JACKSON
59739 LIMA/MONIDA
59746 POLARIS
59761 WISDOM
59762 WISE RIVER
BEAVERHEAD COUNTY TOTAL _____

BIG HORN
59016 BUSBY
59022 CROW AGENCY
59025 DECKER
59031 GARRYOWEN
59034 HARDIN
59050 LODGE GRASS
59066 PRYOR
59075 SAINT XAVIER
59089 WYOLA
59035 YELLOWTAIL
BIG HORN COUNTY TOTAL _____

BLAINE
59523 CHINOOK
59526 HARLEM
59527 HAYS
59529 HOGELAND
59535 LLOYD
59542 TURNER
59547 ZURICH
BLAINE COUNTY TOTAL _____

BROADWATER
59641 RADERSBURG
59643 TOSTON
59644 TOWNSEND
59647 WINSTON
BROADWATER COUNTY TOTAL _____

CARBON
59007 BEARCREEK
59008 BELFRY
59013 BOYD
59014 BRIDGER
59026 EDGAR
59029 FROMBERG
59041 JOLIET
59051 LUTHER
59068 RED LODGE
59070 ROBERTS
59071 ROSCOE
59080 SILESIA
CARBON COUNTY TOTAL _____

CARTER
59311 ALZADA
59316 BOYES
59319 CAPITOL
59324 EKALAKA
59332 HAMMOND
59342 MILL IRON
CARTER COUNTY TOTAL _____

CASCADE
59412 BELT
59414 BLACK EAGLE
59421 CASCADE
59443 FORT SHAW
59401 GREAT FALLS
59402 GREAT FALLS/MAFB
59403 GREAT FALLS
59404 GREAT FALLS
59405 GREAT FALLS
59406 GREAT FALLS
59463 MONARCH
59465 NEIHART
59472 SAND COULEE
59477 SIMMS
59480 STOCKETT
59483 SUN RIVER
59485 ULM
59487 VAUGHN
CASCADE COUNTY TOTAL _____

CHOUTEAU
59520 BIG SANDY
59420 CARTER
59440 FLOWEREE
59442 FORT BENTON
59446 GERALDINE
59450 HIGHWOOD
59460 LOMA
59476 SHONKIN
CHOUTEAU COUNTY TOTAL _____

CUSTER
59336 ISMAY
59338 KINSEY
59301 MILES CITY
59351 VOLBORG
CUSTER COUNTY TOTAL _____

DANIELS
59222 FLAXVILLE
59224 FOUR BUTTES
59253 PEERLESS
59263 SCOBEY
59276 WHITETAIL
DANIELS COUNTY TOTAL _____

DAWSON
59315 BLOOMFIELD
59330 GLENDIVE/INTAKE
59339 LINDSAY
59259 RICHEY
DAWSON COUNTY TOTAL _____

DEER LODGE
59711 ANACONDA
59756 WARM SPRINGS
DEER LODGE COUNTY TOTAL _____

FALLON
59313 BAKER
59344 PLEVNA
59354 WILLARD
FALLON COUNTY TOTAL _____

FERGUS
59418 BUFFALO
59423 CHRISTINA
59424 COFFEE CREEK
59429 DANVERS
59430 DENTON
59438 FERGUS
59441 FORESTGROVE
59445 GARNEILL
59032 GRASSRANGE
59451 HILGER/SUFFOLK
59457 LEWISTOWN/ROSS FORK
59464 MOORE
59471 ROY
59489 WINIFRED
FERGUS COUNTY TOTAL _____

FLATHEAD
59911 BIGFORK/SWAN LAKE
59912 COLUMBIA FALLS
59913 CORAM
59902 CRESTON
59916 ESSEX
59919 HUNGRY HORSE
59920 KILA
59901 KALISPELL/EVERGREEN
59921 LAKE MCDONALD
59922 LAKESIDE
59925 MARION
59926 MARTIN CITY
59927 OLNEY
59928 POLEBRIDGE
59932 SOMERS
59936 WEST GLACIER
59937 WHITEFISH
FLATHEAD COUNTY TOTAL _____

GALLATIN
59714 BELGRADE
59716 BIG SKY
59715 BOZEMAN
59730 GALLATIN/GATEWAY
59763 LOGAN
59741 MANHATTAN
59742 MAUDLOW
59717 MONTANA STATE UNIV
59752 THREE FORKS
59753 TRIDENT
59760 WILLOW CREEK
59758 WEST YELLOWSTONE
GALLATIN COUNTY TOTAL _____

GARFIELD
59318 BRUSETT
59322 COHAGEN
59337 JORDAN
59058 MOSBY
59077 SAND SPRINGS
GARFIELD COUNTY TOTAL _____

GLACIER
59411 BABB
59415 BLACKFOOT
59417 BROWNING/SAINT MARY
59427 CUT BANK
59434 EAST GLACIER PARK
59473 SANTA RITA
GLACIER COUNTY TOTAL _____

GOLDEN VALLEY
59046 LAVINA/CUSHMAN
59074 RYEGATE
GOLDEN VALLEY COUNTY TOTAL _____

GRANITE
59832 DRUMMOND
59837 HALL
59850 MAXVILLE
59858 PHILIPSBURG
GRANITE COUNTY TOTAL _____

HILL
59521 BOX ELDER
59525 GILDFORD
59501 HAVRE/SIMPSON
59528 HINGHAM
59530 INVERNESS
59532 KREMLIN
59540 RUDYARD
HILL COUNTY TOTAL _____

JEFFERSON
59631 BASIN
59632 BOULDER
59721 CARDWELL
59634 CLANCY/MONTANA CITY
59638 JEFFERSON CITY
59759 WHITEHALL/WATERLOO
JEFFERSON COUNTY TOTAL _____

JUDITH BASIN
59447 GEYSER
59452 HOBSON/UTICA
59462 MOCASSIN/KOLIN
59469 RAYNESFORD
59479 STANFORD/WINDHAM
JUDITH BASIN COUNTY TOTAL _____

LAKE
59821 ARLEE
59910 BIG ARM
59824 CHARLO/MOIESE
59914 DAYTON
59915 ELMO
59855 PABLO
59860 POLSON
59929 PROCTOR
59863 RAVALLI
59931 ROLLINS
59864 RONAN
59865 SAINT IGNATIUS
LAKE COUNTY TOTAL _____

LEWIS & CLARK
59410 AUGUSTA
59633 CANYON CREEK
59635 EAST HELENA
59636 FORT HARRISON
59601 HELENA/AUSTIN
59625 HELENA/CARROLLCOLL.
59624 HELENA/DOWNTOWN BXS.
59626 HELENA/FEDERAL BLDG.
59620 HELENA/STATE COMPLEX
59639 LINCOLN
59640 MARYSVILLE
59648 WOLF CREEK
LEWIS & CLARK COUNTY TOTAL _____

LIBERTY
59522 CHESTER
59531 JOPLIN
59461 LOTHAIR
59545 WHITLASH
LIBERTY COUNTY TOTAL _____

LINCOLN
59917 EUREKA
59918 FORTINE
59923 LIBBY
59930 REXFORD
59933 STRYKER
59934 TREGO
59935 TROY
LINCOLN COUNTY TOTAL _____

MADISON
59710 ALDER
59720 CAMERON
59729 ENNIS/JEFFERS
59735 HARRISON
59740 MCALLISTER
59745 NORRIS
59747 PONY
59749 SHERIDAN/LAURIN
59751 SILVER STAR
59754 TWIN BRIDGES
59755 VIRGINIA CITY
MADISON COUNTY TOTAL _____

McCONE
59214 BROCKWAY
59215 CIRCLE
59274 VIDA
McCONE COUNTY TOTAL _____

MEAGHER
59053 MARTINSDALE
59642 RINGLING
59645 WHITE SULPHUR SPRINGS
MEAGHER COUNTY TOTAL _____

MINERAL
59820 ALBERTON
59830 DE BORGIA
59842 HAUGAN
59866 SAINT REGIS
59867 SALTESE
59872 SUPERIOR/TARKIO
MINERAL COUNTY TOTAL _____

MISSOULA
59823 BONNER/POTOMAC
59825 CLINTON
59826 CONDON
59834 FRENCHTOWN
59836 GREENOUGH
59846 HUSON
59847 LOLO
59851 MILLTOWN
59801 MISSOULA
59802 MISSOULA
59803 MISSOULA
59806 MISSOULA
59807 MISSOULA
59808 MISSOULA
59812 MISSOULA/UM
59868 SEELEY LAKE
MISSOULA COUNTY TOTAL _____

MUSSELSHELL
59054 MELSTONE
59059 MUSSELSHELL
59072 ROUNDUP
MUSSELSHELL COUNTY TOTAL _____

PARK
59018 CLYDE PARK
59020 COOKE CITY
59021 CORWIN SPRINGS
59027 EMIGRANT
59030 GARDINER/MINER
59047 LIVINGSTON
59065 PRAY
59081 SILVER GATE
59082 SPRINGDALE
59086 WILSALL
PARK COUNTY TOTAL _____

PETROLEUM
59017 CAT CREEK
59084 TEIGEN
59087 WINNETT
PETROLEUM COUNTY TOTAL _____

PHILLIPS
59524 DODSON
59533 LANDUSKY
59537 LORING
59538 MALTA/WAGNER
59261 SACO
59544 WHITEWATER
59546 ZORTMAN
PHILLIPS COUNTY TOTAL _____

PONDERA
59416 BRADY
59425 CONRAD
59456 LEDGER
59432 DUPUYER
59448 HEART BUTTE
59486 VALIER
PONDERA COUNTY TOTAL _____

POWDER RIVER
59314 BIDDLE
59317 BROADUS/BELLE CREEK
59325 EPSIE
59343 OLIVE
59062 OTTER
59345 POWDERVILLE
59348 SONNETTE
POWDER RIVER COUNTY TOTAL _____

POWELL
59713 AVON
59722 DEER LODGE/GALEN
59728 ELLISTON
59731 GARRISON
59733 GOLDCREEK
59843 HELMVILLE
59854 OVANDO
POWELL COUNTY TOTAL _____

PRAIRIE
59326 FALLON
59341 MILDRED
59349 TERRY
PRAIRIE COUNTY TOTAL _____

RAVALLI
59827 CONNER
59828 CORVALLIS
59829 DARBY
59833 FLORENCE
59835 GRANTSDALE
59840 HAMILTON
59841 PINESDALE
59870 STEVENSVILLE
59871 SULA
59875 VICTOR
RAVALLI COUNTY TOTAL _____

RICHLAND
59217 CRANE
59220 ENID
59221 FAIRVIEW
59243 LAMBERT
59262 SAVAGE
59270 SIDNEY
RICHLAND COUNTY TOTAL _____

ROOSEVELT
59212 BAINVILLE
59213 BROCKTON
59218 CULBERTSON
59226 FROID
59245 McCABE
59255 POPLAR
59201 WOLF POINT/OSWEGO
ROOSEVELT COUNTY TOTAL _____

ROSEBUD
59312 ANGELA
59003 ASHLAND
59012 BIRNEY
59323 COLSTRIP
59327 FORSYTH
59333 HATHAWAY
59039 INGOMAR
59043 LAME DEER
59346 ROCK SPRINGS
59347 ROSEBUD
59083 SUMATRA
ROSEBUD COUNTY TOTAL _____

SANDERS
59831 DIXON
59844 HERON
59845 HOT SPRINGS
59848 LONEPINE
59852 NIRADA
59853 NOXON
59856 PARADISE
59857 PERMA
59859 PLAINS
59873 THOMPSON FALLS
59874 TROUT CREEK
SANDERS COUNTY TOTAL _____

SHERIDAN
59211 ANTELOPE
59216 COALRIDGE
59219 DAGMAR
59242 HOMESTEAD
59247 MEDICINE LAKE
59252 OUTLOOK
59254 PLENTYWOOD
59256 RAYMOND
59257 REDSTONE
59258 RESERVE
59275 WESTBY
SHERIDAN COUNTY TOTAL _____

SILVER BOW
59701 BUTTE/WALKERVILLE
59702 BUTTE
59703 BUTTE
59727 DIVIDE
59743 MELROSE
59748 RAMSAY
SILVER BOW COUNTY TOTAL _____

STILLWATER
59001 ABSAROKEE
59019 COLUMBUS
59028 FISHTAIL
59067 RAPELJE
59069 REEDPOINT
59057 MOLT
59061 NYE
59063 PARK CITY
STILLWATER COUNTY TOTAL _____

SWEET GRASS
59011 BIG TIMBER
59033 GREYCLIFF
59052 McLEOD
59055 MELVILLE
SWEET GRASS COUNTY TOTA _____

TETON
59419 BYNUM
59422 CHOTEAU
59433 DUTTON
59436 FAIRFIELD
59467 PENDROY
59468 POWER
TETON COUNTY TOTAL _____

TOOLE
59435 ETHRIDGE
59437 FERDIG
59444 GALATA
59454 KEVIN
59466 OILMONT
59474 SHELBY/DEVON
59482 SUNBURST
59484 SWEETGRASS
TOOLE COUNTY TOTAL _____

TREASURE
59010 BIGHORN
59038 HYSHAM/MYERS
59076 SANDERS
TREASURE COUNTY TOTAL _____

VALLEY

59223 FORT PECK
59225 FRAZER/LUSTRE
59230 GLASGOW/TAMPICO
59231 GLASGOW/AFB
59240 GLENTANA
59241 HINSDALE
59244 LARSLAN
59248 NASHUA
59250 OPHEIM
59260 RICHLAND
59231 SAINT MARIE
59273 VANDALIA

VALLEY COUNTY TOTAL _____

WHEATLAND

59036 HARLOWTON
59453 JUDITH GAP
59078 SHAWMUT
59085 TWODOT

WHEATLAND COUNTY TOTAL _____

WIBAUX

59320 CARLYLE
59353 WIBAUX

WIBAUX COUNTY TOTAL _____

YELLOWSTONE

59002 ACTON
59006 BALLANTINE
59101 BILLINGS
59102 BILLINGS
59103 BILLINGS
59104 BILLINGS
59105 BILLINGS/BILLINGS HT
59106 BILLINGS
59107 BILLINGS
59015 BROADVIEW
59024 CUSTER
59037 HUNTLEY
59044 LAUREL
59064 POMPEYS PILLAR
59079 SHEPHERD
59088 WORDEN

YELLOWSTONE COUNTY TOTAL _____

UNKNOWN INSTATE TOTAL _____

OUT OF STATE TOTAL _____

TOTAL FOR ALL COUNTIES _____

INSTRUCTIONS FOR HOSPITALS

Address: Please write the name and address of the facility on Page 1 of the survey.

Copies: Mail or fax a typed or clearly printed copy to: Department of Public Health and Human Services, Certificate of Need Program, 2401 Colonial Drive, 2nd Floor, P.O. Box 202953, Helena, Montana 59620-2953. This survey may be submitted electronically to psourbeer@mt.gov. **Keep a copy of the survey for your files**.

Note: Answer every item. Enter "O" to mean none; enter "N/A" to mean data that is not available from your records.

A. REPORTING PERIOD

The preferred reporting period is January 1, 2006, through December 31, 2006. It is permissible to use a different 12-month period, but please be consistent from year to year, and indicate the time period used.

B. CLASSIFICATION

1. The following definitions apply to this section of the survey:

Not For Profit:	Excess revenue retained by the corporation; exempt from federal income taxation under section 501 of the Internal Revenue Code of 1954.
For Profit (Proprietary):	Excess revenue distributed to owners or shareholders or held as retained earnings, subject to federal taxation.

2. Please indicate the governmental entity (state, city, county or federal), corporation, company, etc., responsible for the ownership and management of the agency.

C. UTILIZATION OF BEDS AND SERVICES. Report utilization for a full 12-month period.

9. "Other" should NOT include any long-term care facility (skilled nursing) beds operated as part of a combined facility. The utilization of long-term care beds should be reflected on the facility's Annual Survey of Long-Term Care Facilities.

11. "Swing beds" should include only those beds certified as swing beds; other long-term care facility (skilled nursing) beds should NOT be included in this section.

E. PERSONNEL DATA. Exclude volunteers and all personnel whose salary is financed entirely by outside research grants.

For combined facilities, report **ONLY** the personnel for the hospital.

F. FINANCIAL DATA. Report expenses for the full 12-month period. If actual figures are not available, please estimate (indicate which figures have been estimated). Please do not use □N/A□ in this section. Round all figures to the nearest dollar.

1. a. Total gross revenue: Includes total revenues from direct patient care and all other sources.
   b. Payroll expenses: Report salaries for full-time and part-time personnel as reported in section E, Personnel Data.
   c. Non-payroll expenses: Include all costs for goods and services that have been used or consumed during the reporting period.

Compare financial data with 2005 Annual Survey financial data and explain any differences exceeding 10%.

G. PATIENT ORIGIN DATA. Report all patients discharged from the facility for the reporting year by zip code and county of origin. Please total discharges from all counties on page 8.

If you have any questions, please contact the Certificate of Need Program, Montana Department of Public Health and Human Services, 2401 Colonial Drive, 2nd Floor, P.O. Box 202953, Helena, Montana 59620-2953. Telephone (406) 444-9519, Fax (406) 444-1742 or E-Mail psourbeer@mt.gov